



OFFICE OF THE CITY ATTORNEY

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Medical or Treatment Records:

Name: _____

Date of Birth: _____

Telephone Number: _____

Authorization for Use/Disclosure of Information:

I voluntarily authorize and direct the City of Long Beach to disclose my health information during the term of this Authorization to the recipient that I have identified below.

Record Recipient:

To: _____

Recipient Name (May be Patient or Authorized Representative(s))

Recipient Address: _____

Recipient Telephone Number: _____

Purpose:

I understand that the specific purpose of this Authorization is:

Information to be Disclosed:

This authorization permits the City of Long Beach to disclose the following medical records:

_____(Initial) All of my health information that the City of Long Beach has in its possession, including information relating to any medical history, mental or physical condition and any treatment received by me, including without limitation, x-rays, genetic testing, psychotherapy notes and other mental health information, drug, alcohol or other controlled substance information, billing information, correspondence, and records from other health care providers that the City of Long Beach may hold.

_____(Initial) I **SPECIFICALLY AUTHORIZE** the release of HIV/Aids test results or any other information in the custody of the City related thereto.

_____(Initial) I **SPECIFICALLY AUTHORIZE** the release of all psychotherapy or other mental health records or information.

_____(Initial) I **SPECIFICALLY AUTHORIZE** the release of all drug, alcohol or other controlled substance records or information

_____(Initial) I **DO NOT** authorize the release of the following described medical records:

This authorization will remain in effect until _____[date]. After that date you are no longer authorized to release any medical, dental, laboratory, or hospital records concerning me without further written authorization.

_____[Date]

_____[Patient's signature]

_____[Print name]